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The Politics of Covering Undocumented Children:

A Look at State Experience

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Overview

Three states (MA, NY, RI) and the District of Columbia (hereafter referred to as a state) offer health coverage to undocumented children through a variety of means. A much larger number of states – seventeen – offer coverage to legally present but not federally qualified children.[1] These include children who are legally present but are ineligible for federal matching dollars due to restrictions enacted by Congress in 1996.[2] Interviews were conducted with stakeholders from these four states to assess how this coverage came into place, whether its existence has been threatened in recent tough budget climates, and what strategies prove successful in assuring coverage for these children. Profiles of each state are attached.

Findings

- **Public fights to obtain and retain coverage have, for the most part, minimized the visibility of undocumented children in the covered populations.** Some of the programs examined cover citizen children at higher income levels and others cover immigrants in a variety of statuses. Generally, advocates have been very careful to frame their message as one of universal coverage for children and/or to highlight other covered populations.
- **In the view of most respondents, the lack of federal matching funds is the primary factor making programs vulnerable to budget cuts and/or inadequate funding.** In three of the four states examined, the program has been threatened with cuts or received inadequate funding to serve all those children who are potentially eligible. Anti-immigrant sentiment did not seem to be the primary cause of proposed or actual budget cuts or other limitations. Cuts were targeted to programs or aspects of programs that did not bring in federal matching funds.
- **Legislative staff interviewed tended to stress the effectiveness of a preventive care message, i.e. pay now or pay more later.** Advocates also frequently mentioned this message, but were generally more focused on a universal coverage message.
- **Competing political dynamics are at work.** On the one hand, the growing influence of the Latino and other immigrant communities was cited by many as an important political protection for the program. On the other hand, tough budget times have threatened coverage and, in some cases, may contribute to anti-immigrant sentiment when resources become scarcer.
- **For the most part covering undocumented children does not appear to be a partisan issue in these states.** In some cases, there has been active or tacit support by Republican Governors. Cuts proposed by a Republican Governor in one state were part of larger budget trimming efforts. Legislators have not overtly divided on partisan lines.

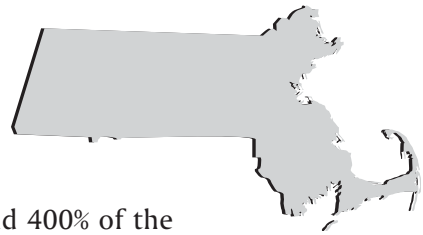
- **Providers, while generally supportive, have not been very engaged in the fight to get and keep coverage.** This probably reflects the fact that, in general, there were no separate and distinct campaigns to secure coverage for undocumented children. With respect to budget fights, providers were engaged to some degree but were probably engaged in other aspects of these fights that were of a higher priority to them.
- **A potential ally that has been used in limited ways but could perhaps be more actively engaged is the religious community.** In particular, the Catholic Church and related faith-based providers are very active in a range of immigrant issues and have engaged in efforts to secure or retain coverage to a limited degree. This approach may be a fruitful one if pursued ,according to some respondents.
- **Counties either do not exist or have played no role in the politics and provision of coverage in all four of the states offering coverage.**

State Profiles

Massachusetts[3]

Overview:

Massachusetts provides comprehensive primary and preventive care (including well and sick-child care, immunizations, vision, hearing, dental and mental health care, outpatient surgery, tests etc.) to undocumented children primarily through the Children's Medical Security Plan (CMSP). Since CMSP does not offer an inpatient hospital benefit, CMSP children are automatically determined eligible for free inpatient care through the state's Uncompensated Care Pool, and emergency coverage is of course offered through Medicaid. CMSP offers coverage to all children ineligible for Medicaid either as a result of income or immigration status. Children between 200% and 400% of the federal poverty line (FPL) pay premiums and children over 400% of FPL must pay the full cost of the coverage. Thus CMSP covers a significant number of higher-income citizen children as well as immigrant children, including but not limited to undocumented children.



The program is funded from state General Revenue. In November 2002, enrollment was capped at approximately 26,000 and a waiting list was established. For FY2005, after a successful legislative effort discussed below, CMSP was fully funded and is expected to enroll the 4,000 children who have been on the waiting list.

How did CMSP come about?

CMSP was created as part of a much larger universal health care coverage bill in 1988, much of which was subsequently repealed. Originally it was one of several "interim" programs intended to phase out when the law's "pay or play" provision was implemented. When the "pay or play" provision was repealed, CMSP stayed in place.

CMSP began enrolling children under the age of 13 in 1994. The program was later expanded in 1998 to cover all children up to age 18. Over time, and in light of expansions to the MassHealth program (the name of the Massachusetts Medicaid program) for citizen children, the proportion of undocumented children in CMSP has grown.

As CMSP was a small piece of a much larger overall package, it was not created with the purpose of covering undocumented children. There was virtually no discussion of covering undocumented children when the program was created, and legislators were generally not aware that this was part of the package they were voting on. Advocates made a conscious decision not to mention it.

Has the coverage been threatened?

Yes. Funding levels have fluctuated over the years as a result of budget issues. Shortly after the program's inception in 1994, enrollment was closed. After the passage of the State Children's Health Insurance Program (SCHIP), when MassHealth was expanded with SCHIP funding and some citizen children were moved out of CMSP, eligibility was extended for children ages 13-18 and benefits were added. In FY2001, some benefits were decreased or eliminated, and, in November 2002, enrollment in CMSP was capped again.

Most recently, the Governor's FY2005 budget proposed a number of changes to further reduce expenditures in CMSP including raising premiums for higher-income children, imposing premiums on children between 150% and 200% of poverty, and limiting benefits. It is estimated that these changes, if enacted, would have further reduced coverage for children in CMSP by 4,000 because of the increased premiums.[4] The primary motivation for proposing the cuts appeared to be fiscal rather than anti-immigrant sentiment; the state was experiencing a serious budget crisis, a range of programs serving immigrants as well as other programs not eligible for federal match were targeted for cuts. However, immigrant and health advocates did note that Governor Romney has repeatedly vetoed attempts to restore benefits for legally present immigrants, and that this Governor, in their view, is more "anti-immigrant" than previous Republican Governors.

Subsequent to the Governor's budget proposal, child health advocates waged a vigorous campaign to fully fund the program. A coalition funded in part by Children's Hospital, with the active participation of pediatricians and led by the state's main health care advocacy group, Health Care for All, succeeded in adding funding to the program in order to open enrollment. Because the immigrant community was facing a range of cuts, Latino leaders and immigrant leaders were not the primary actors – the child health community was. This appears to have been a tacit decision based on available resources and messaging considerations.

The coalition made a conscious decision to feature higher income citizen children in its campaign. The presence of the waiting list, with good data on where these children lived, allowed the coalition to target legislators from a wide range of communities very effectively. Because of the presence of higher-income children on the waiting list, children from virtually every legislative district stood to benefit from the additional funding. It is important to note that while some ma-

terials developed by the coalition mention the impact on immigrant children, there was a conscious effort to downplay this population and focus on coverage for all children. The importance of primary and preventive care for children was also emphasized.

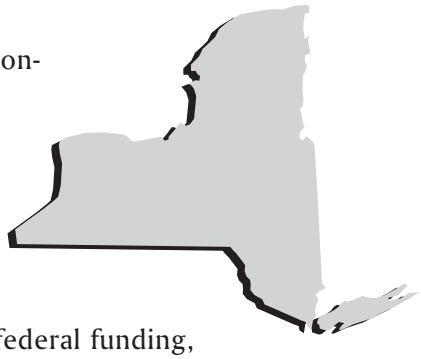
Key Points:

The twin pillars of the successful campaign were a moral pitch to cover **all** children along with a fiscal responsibility message that stressed the value of funding primary and preventive care for children in order to minimize emergency room and hospital costs and contribute to more successful school outcomes. Immigrant specific messages (i.e. these families are working, paying taxes etc) were not the focus of the campaign to open enrollment in CMSP.

New York[5]

Overview:

New York covers undocumented children through the state's Child Health Plus (CHPlus) program. CHPlus is the state's SCHIP program, although its existence in a more limited version predates passage of federal SCHIP legislation. Undocumented children are covered entirely at state cost. The state share of funding for CHPlus in general is provided entirely through state funds; unlike Medicaid in New York, counties do not contribute to CHPlus funding.



As a result of litigation brought in 2001, legal immigrant children who are ineligible for federal funding due to federal restrictions such as the five-year bar are now provided coverage through the Medicaid program[6] *or* through CHPlus depending on their family income. Prior to the litigation all children who were not qualified for federal funding, regardless of their immigration status, were served by CHPlus. However, children who are undocumented have always been and continue to be served — regardless of income—in CHPlus.

How did the program come about?

Child Health Plus was signed into law on July 31st, 1990 by then Governor Cuomo following legislative action to create the program. The intent of the program was to serve children ineligible for Medicaid. Enrollment began in 1991. Initially the program was very small and served only children up to age 13 with a limited package of outpatient services. Today the program serves all children up to age 19 with a more generous benefits package —changes that resulted from expansions over the years.

At the time of its passage, there was no public, and little if any, private discussion of coverage of undocumented children through CHPlus. The chief legislative sponsor of the bill was the Chair of the Health Committee who recalls that he was unaware at the time that undocumented children were going to receive coverage. At some point in the process, discerning readers of the bill realized that defining eligibility in terms of New York residency would permit all immigrants who were living in the state to be eligible, but this information was not widely known. Legislators were definitely not aware of this when they voted. The most contentious issue during the initial debate surrounding the program was coverage of 13-18 year olds because of concerns about state funding of abortion.

At the time that federal SCHIP funds became available and the CHPlus program was expanded, there was a conscious decision to keep coverage of undocumented children "under the radar screen" but to ensure administratively that undocumented children would remain eligible for the state-funded categories of the program.

Has this coverage ever been threatened?

No. Cuts to CHPlus have not been an issue as the program has strong political support. Governor Pataki has not proposed any cuts and neither have legislators, even when other health cuts were proposed. The state's Program Administrator stated that she had never heard negative sentiments expressed on this topic while she has encountered other anti-immigrant feelings.

There is a tacit agreement between state officials and child and immigrant advocates to keep a low profile for the coverage of undocumented children politically, although state officials and advocates do publicize the availability of coverage for immigrant children quite aggressively through outreach efforts. There is widespread awareness of the program among the immigrant community, providers, and certainly among state officials. Many legislators are probably unaware, however, that so many undocumented children are being served through this program.

Key Points:

In general, the climate in New York State towards immigrants is probably the most favorable in the country. In addition, Child Health Plus is a very popular program. There was virtually unanimity in the assessment that the coverage of undocumented children is and has been strongly supported in many quarters. This view is tempered, however, by concerns about raising the visibility of this coverage and the reality that the legislature has never publicly debated the issue. Nonetheless, coverage of undocumented children in New York State is perhaps the most secure of the states examined.

Rhode Island[7]

Overview:

Rhode Island serves approximately 2500 children who are not federally qualified (including undocumented children) through its Medicaid program – RiteCare – but does not claim federal matching funds for these children. A precise estimate of the number of undocumented children served is unavailable. Undocumented children receive the full Medicaid benefits package. Funding for the state-funded component of the coverage comes from the state's General Revenue funds.

How did the program come about?

In the wake of restrictions on coverage due to federal welfare reform and immigrant eligibility changes, health advocates started a legislative campaign in 1997 to get all children covered in Rhode Island. In 1997, advocates were successful in getting legally present but not federally qualified children covered, and following a lengthy, but *not* highly visible campaign, eligibility for all children was extended in 1999.

Initially, advocates were not highly confident of success. A skilled advocacy campaign, the active support of a few key legislators, the growing influence of the Latino community, the tacit support of state program administrators, and the general popularity of the RiteCare program and its publicized role in improving health outcomes for children combined to make the campaign to extend coverage a success. Providers, by and large, were not engaged in the initial effort to extend coverage.

What were the main messages used to argue for extending coverage?

The primary message was the importance of providing coverage to *all* children, but secondary messages such as the public health consequences of having children in schools that were not immunized were also used. Two of the key legislative champions, who both held leadership positions, were teachers who had seen undocumented children in school and were eloquent and aggressive spokespeople on the realities that these families face. The main opposition to extending coverage was budgetary, so proponents stressed the economic benefits of funding primary and preventive care. Some "anti-immigrant" concerns were expressed – such as families coming to Rhode Island specifically to use the health services – but opposition was primarily fiscal.

Has the coverage been threatened?

Yes. In 2002, the House Finance Committee voted almost unanimously to phase-out coverage for immigrant children for whom the state was not receiving federal matching payments. Legislators who had championed the program at its inception were no longer in the legislature. All those interviewed stressed that the driving force behind this action was the need to save state General Revenue funds and not anti-immigrant sentiment. Cuts in RiteCare were being considered in other areas and, because federal matching funds are not available for this group, as the state's

Medicaid Administrator pointed out, legislators could maximize their General Revenue fund savings with a smaller eligibility cut than would be required if a population eligible for federal match was eliminated.

Advocates waged a very public campaign this time and were able to reinstate funding in the one-week period between the budget leaving committee and going to the floor. In a rare move, advocates sought to have an amendment offered on the floor which would put legislators on record for or against explicitly stripping out coverage for immigrant kids who were ineligible for federal match. Because this was an election year, and given the growing importance of the Latino vote in particular, and immigrant communities more broadly, legislators were reluctant to go on record opposing coverage. A deal was made before the amendment was voted on and coverage was fully maintained. In addition to broader political considerations, the most compelling argument made for legislators, in the view of legislative staff, was the cost-effectiveness of providing preventive care to these children.

Key Points:

When coverage for undocumented children was initially secured, advocates consciously chose to not highlight this population but focus on a broader "cover all kids" message. Yet coverage was finally secured after other groups had been covered meaning as a practical matter that undocumented children were the only group being advocated for. Thus, unlike in other states, coverage for undocumented children was won and retained through two successful and explicit, if not high profile, legislative debates.

Washington, DC

Overview:

The District of Columbia provides full Medicaid coverage to a capped number of immigrant children who are not federally qualified, regardless of status. Enrollment began on June 1, 2000 with funding for 500 children. Currently the program is serving 833 children at a cost of $2.4 million per year.[8] Funding for the program is appropriated by the City Council. A waiting list is maintained for the program; when children terminate or age out of coverage their spot is filled by someone from the waiting list. The city does not allow the waiting list to grow larger than 100; currently there are between 50-75 children on it. Because enrollment is capped, the program is not enrolling new children on a regular basis. Advocates estimate that there are additional 400-500 children who need coverage but are not permitted to get on the waiting list or are unaware of the program.

How did the program come about?

Following the passage of federal welfare reform legislation in 1996 which restricted access of many immigrants to a range of public benefits, there was much concern in DC. Community advocates, primarily from the Latino community, pushed for the broadest eligibility possible for children under the city's "replacement" program. According to advocates, the late Paul Offner, who was then the head of the city's Medicaid program, was a driving force behind extending coverage to all children regardless of status. The City Council did have a debate and, largely as a result of the strong support of the Medicaid agency and immigrant service providers, the program was approved with strong support in the Council. Enrollment was capped, largely in response to fiscal concerns.

Who was involved in the public debate and how?

Concerns raised about starting the program were largely fiscal; anti-immigrant sentiment was not a primary reason either explicitly or implicitly in the opposition. Some concerns were raised, however, about the city becoming a "magnet" for undocumented immigrants if generous benefits were offered. Providers were not very engaged in the debate; indeed advocates had to argue against an idea promoted by the hospitals to only cover catastrophic care for undocumented immigrant adults and children.

A key staffer for a City Council member underscored that the growing influence of the Latino and other immigrant communities along with the fact that the District is a generally liberal city combined to create goodwill among elected officials.

Has the coverage been at-risk?

Funding for the children currently covered has not been threatened in any meaningful way since the program was created. However, advocates would like to expand funding for the program so that the cap on enrollment could be lifted. At the time the cap was reached, advocates engaged in discussions with the department about lifting it, but there was little public discussion and these efforts were unsuccessful. Because enrollment is largely closed, awareness of the program within the community is diminishing.

Efforts to lift the cap have not been successful in part because much of the debate on public health care coverage over the past few years has been around the Mayor's proposal to close the city's primary public hospital and create a health care alliance to cover more of the uninsured. Undocumented adults have been covered to some degree through the alliance which has detracted attention from efforts to expand coverage for children. Advocates feel that the effort to raise the cap has lost momentum and are not actively pursuing it.

Endnotes

[1]Fremstad, S. and L. Cox, "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' eligibility and Access to Publicly Funded Health Insurance," (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, forthcoming).

[2] This report focuses on just those four states that offer coverage to undocumented children.

[3] Unless otherwise noted, information is drawn from six interviews conducted with people in Massachusetts, the state's Medicaid Director and the CMSP Program Manager (who submitted a joint written response), a key legislative staffer, and four health and immigrant advocates.

[4] Enrollment loss estimated based on increased premiums. Small Savings, Big Losses: Cutting the Children's Medical Security Plan, Undoing Children's Health Care in Massachusetts Children's Health Access Coalition, Boston, MA, April 2, 2003. Available on the web at www.hcfama.org/_uploads/documents/live/childhealth_report.pdf

[5]Unless otherwise noted, information is drawn from seven interviews with a Deputy Commissioner in the State Department of Health, a key legislator, two representatives of the hospital community, and three child health and immigrant advocates.

[6] Aliessa et al v. Novello (NY CT. App. June 5, 2001).

[7] Unless otherwise noted, information is drawn from four interviews conducted with the state's Medicaid Administrator, the Policy Director for the Rhode Island Senate's Health and Human Services Committee and two key health care advocates.

[8] Interview with Kate Jesberg, Administrator Income Maintenance Division, District of Columbia Department of Human Services, 8/3/04. Other interviews were conducted with the leading immigrant health advocate and a key city council staffer.